

HIPAA Authorization Form FORM GM 509b

For the Use and Disclosure of Individually Identifiable Health Information
I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re- disclosed and no longer protected by federal privacy regulations.

This authorization expires on _____

Persons/organizations authorized to use and/or disclose the information:
Seacoast Neurofeedback, LLC, Tom Maxwell, RN

Persons/organizations authorized to receive the information:

Specific description of information that may be used/disclosed:

The information will be used/disclosed for the following purposes:

I understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that Seacoast Neurofeedback, LLC will not condition treatment, payment or enrollment in a health plan based on this authorization. I understand that I may revoke this authorization at any time by notifying the Seacoast Neurofeedback, LLC in writing. However, the revocation will not be valid if:

1. Seacoast Neurofeedback, LLC has taken action in reliance on this authorization;
or
2. If this authorization is obtained as a condition for obtaining insurance coverage, other law provides
the insurer with the right to contest a claim under the policy or the policy itself.

Please sign below:

Signature

Printed Name

Date

Notary Name & Seal

If the above signature is that of a patient representative, please attach the appropriate legal documentation.

Signature /Title

Date